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COMMUNICATIONS.

INSTRUMENTAL DIAGNOSIS.

By PHILIP S. WALES, M. D.,

Of Philadelphia.

(Continued from page 229.)

**VIII. PATHOLOGICAL CONDITION REVEALED
BY THE LARYNGOSCOPE.**

1. Congestion of the laryngeal mucous membrane. This condition of the mucous membrane of the larynx is a most frequent one. It is induced by slight causes: the contact of irritating vapors floating in the air, vicissitudes of temperature, unusual and violent exercise of the vocal organs, the passage of hot fluids over the epiglottis, as hot water, and as mentioned by GERHARDT, in his own case, even after taking a warm cup of strong tea, he has often suddenly felt as if a foreign body were in the larynx, accompanied by a desire to cough, and a hoarseness lasting several hours, all of which phenomena vanish by the following morning. The mirror shows each time a swelling of the inter-arytenoid fold of mucous membrane.

The prolonged use of the mirror will often produce a slight congestion of the laryngeal mucous membrane, attended with a feeling of roughness, tickling and dryness. In my own case, I have for several hours after each sitting a very disagreeable sensation of rawness, and the membrane becomes very red; but this has never as yet extended to the vocal cords. Such a condition of these cords are, however, recorded as resulting from a protracted inspection, particularly in those cases in which there is already some little laryngeal catarrh.

Chronic congestion is also often noticed in connection with phthisis, in the second and third stages, and other diseases.

Congestion is revealed by the mirror, which shows in some cases the mucous membrane covering the arytenoid cartilages, ventricular bands and aryteno-epiglottic folds of a deeper purplish shade than natural, and even the vocal cords invaded by a roseate tint. In other instances, the congestion becomes chronic and these parts are not only more deeply colored, but thickened; the vocal cords sometimes being almost hid by the swelling above, lose their elasticity, and do not vibrate with normal freedom, and hence the voice is altered in character, becoming hoarse, cracked, or whispering or is even abolished altogether. In some cases, an over-distended vessel is ruptured, coloring the sputa with reddish streaks or specks, or being more intimately blended, forms a brownish fluid. A case of this sort is related by SEMELEDER, of a man about forty-five years of age complaining of tickling and a slight scratching in the larynx, which compelled him to clear his throat frequently. There was no cough; the voice was slightly altered; no real pain. The sputa was raised without difficulty, and consisted of lumps of mucus, with some air vesicles. Sometimes there were streaks of blood mingled with the sputa, but in the morning its color was a brownish red. There were a few granulations and varicose veins in the pharynx. The epiglottis, the entrance to the larynx, and the ventricular cords had quite a normal appearance. The vocal cords, a little way from both their anterior and posterior attachments, were slightly reddened. Upon the anterior extremity of the left ventricular cord there was a small hemorrhagic spot, and upon it a slight fibrinous clot. This point was considered as the source of the hemorrhage, and explained the appearance of the red streaks in the sputa during the day, by the pouring out of fresh blood when the throat was cleared, while the

blood which oozed out in the course of the night would give the reddish color to the morning discharge, in which it was diffused. These appearances lasted for three weeks.

Other cases have been recorded of hemorrhagic extravasation in various portions of the laryngeal mucous membrane, but the foregoing one seems fully to illustrate this accompaniment of congestion.

LARYNGEAL INFLAMMATION.

The consideration of congestion of the laryngeal mucous membrane leads us naturally to consider in the second place its inflammation. Laryngitis presents itself under several forms, which require to be separately considered.

2. Catarrhal laryngitis may be acute or chronic, and in either case may differ in intensity. There is but a step from the congestion which is described in the previous section and the lighter form of acute laryngitis, the two pathological conditions running into each by imperceptible gradations. We find in the latter also the same diffused redness of the mucous membrane, or, as sometimes happens, patches of redness found by enlarged vessels. The redness varies from a light roseate hue to deep red. The disease may be associated with general catarrh of the respiring passages or be limited to these parts of the larynx. In the latter case a stricture may be separately affected, or the epiglottis, aryteno-epiglottic fold, and ventricular bands, or all of them, at the same time. The mucous membrane covering these parts will be found thickened and more glossy than natural, with here and there a string or lump of mucous adherent, or stretching from one to another. When the epiglottis is much altered in the above manner (epiglottitis) it presents the appearance of a short, thick, nipple-like projection, occupying much of the super-glottic space and rendering an inspection of the parts below more difficult. In some cases the epiglottic swelling is limited to one or other of the two surfaces, or even to a moiety of it.

When the disease is more advanced in, or principally confined to, the deeper parts, aryteno-epiglottic folds, ventricular bands, or to the mucous membrane, covering the arytenoid and Wrisberg cartilages, they will present increased volume and redness, easily recognizable in the mirror, and in the latter case the swelling of the arytenoid cartilages will im-

pair the motion of the vocal cords so that they cannot be approximated sufficiently for vocalization. These cords may also be involved, so that they lose their pearly shimmer, and present some shade of red from the lightest to the deepest, become thickened and altered in shape, so that their edges no longer present a thin, sharp appearance.

If the inflammation extends deeper still, the mucous membrane of the trachea may also be observed altered in color, but rarely to such a degree that the glistening of the cartilaginous rays beneath may not be seen.

The symptoms connected with this mild degree of catarrhal laryngitis, are alterations in the timbre of the vocal cough, pain, upon pressure being made on the larynx, difficulty in swallowing and dyspnoea. The voice is either hoarse or cracked, and in attempts to speak the tone often passes by a rapid transition from grave to acute, or lastly, there may be a complete aphonia. There is often a sense of pricking, or a feeling as if there were a foreign body above the superior laryngeal aperture, which provoke cough. It is also induced by the injection of cold liquids, or aliment coming in contact with the parts denuded of epithelium. During the act of coughing pain is experienced from the movement of the inflamed and tender laryngeal structures upon each other. Difficulty in swallowing arises from the swollen condition of the parts, and the pain induced in them by the contact of drinks and food, by imperfect closure of the larynx, by the epiglottis with the parts about the laryngeal aperture. Dyspnoea is usually not present in the mildest catarrhal laryngitis, but in a higher degree, when the vocal cords and the adjacent parts are swollen, the laryngeal aperture will be more or less trenched upon, and cause dyspnoea in proportion to its extent. There is expectorated white, frothy sputa. This degree of acute laryngitis is commonly encountered in persons who have exposed themselves to vicissitudes of temperature, or those who use the vocal organs to excess in speaking or singing. These cases run a course of two or three weeks, and are easily amenable to simple remedies.

In the higher grades of acute laryngitis these appearances already described will be seen more marked, and after a few days small ulcers will form at some points upon the epitheliless, mucous membrane particularly upon the

epiglottis, runs its free border when it passes upon the cartilages of Santorini during the act of swallowing, upon the aryloid Santorini cartilages, the points of the vocal processes the anterior angle of the glottis, and upon the vocal cords. The symptoms we have mentioned, accompanied by mild acute laryngitis, will also in this grade be more marked.

Chronic catarrhal laryngitis eventuates either the acute form, when the latter has been successfully treated, or it arises spontaneously from some peculiarity of the constitution, or of the mode of action of the cause producing it.

The milder degrees of chronic laryngitis are very common; we see it habitually in those who exercise the voice continuously and violently; speakers, hawkers, singers, and especially in those who, besides having to make continuous drafts upon the vocal power, indulge to excess in alcoholic drinks and tobacco smoking. The inhalation of irritating substances in powder or vapors, for a long period, will also result in this form of laryngitis. It is also found associated with phthisis and syphilis.

The mucous membrane is found deep red; sometimes bluish-red, thickened and often having patches of granulation, or ulcers at some other part of its surface. The alteration of the voice is now marked and continuous; pain and cough are almost entirely wanting. In severe chronic laryngitis the local changes are more marked still, the hypertrophy of the membrane is greater; sometimes there is a shrinking of the mucous and submucous tissue from atrophy, and the change may even extend to the cartilages beneath. The vocal cords are also changed in color, becoming reddish, sluggish in movement, and thicken, or, in some cases, atrophied and yellowish. Not unfrequently propelling growths, swelling of the follicles, and the formation of small mucous polypi, form a link in these chronic changes. There will be more or less dyspnoea, and impairment of the voice or aphonia.

Chronic laryngitis runs a prolonged course, has a constant disposition to relapse, and is difficult of cure.

III. PSEUDO-MEMBRANUS LARYNGITIS, OR CROUP.

Laryngoscopically there is little to present to the reader concerning croup, and the same remark may be made regarding diphtheria. Both of these forms of inflammation are accompanied with deposits of greater or less extent in the larynx, and the appearances fur-

nished in both cases are pretty nearly the same. STÖRK, as quoted by SEMELEDER, describes a case that may be regarded as croupous inflammation. It occurred in a young lady twenty-four years old, who had suffered for some time from an irritation and tendency to cough, and from hoarseness, without any known cause. The organs of the chest were normal. The laryngeal mirror showed a thick exudative deposit beneath the vocal cords, and also upon the interior larynx, that so far diminished the laryngeal space in circumference as to cause frequent attacks of suffocation. Spasmodic coughing ensued, by means of which the exudation was sometimes expelled. A ring-shaped mass of grayish yellow color, compact and viscid, was formed at some points, hard like an eschar, and streaked with blood; it consisted of mucous globules, pus cells, and fat, without manifest stricture. According to the inspection, and from the breadth of this exudation, the disease must have extended beyond the cricoid cartilage. In other respects the larynx was perfectly normal. A cure followed the cauterization with a concentrated solution of nitrate of silver, although frequent relapses occurred.

Semeleder himself also reports the laryngoscopic character of a case of diphtheria. The patient was a girl twelve years old; greatly wasted away at the time of the examination, and suffering greatly from difficulty of breathing. The examination of the pharynx showed that the mucous membrane, upon the lower half of its posterior wall, as well as upon the palate and its arches, was, in a marked degree, bluish-red and hyperemic; in some places it was destroyed, and in others covered with small ecchymoses and a few greyish-yellow shreds. The examination with the laryngoscope was quite easy; it revealed the epiglottis blueish-red and covered for the most part with a thick, yellowish-white pseudomembrane and oedema, and contractive at the entrance of the glottis. The vocal cords were colored yellow, but below these, and quite deep down, as far as could be seen, the mucous membrane of the trachea was covered with a grayish-yellow, dirty, dingy deposit contracting the space; here and there it hung in shreds from the sides; it was about one line in thickness, and through it the surface beneath could be seen, having a deep bluish-red color and a spotted uneven appearance. The diagnosis of diphtheria was easily made, and

it appeared that the process had commenced above and had extended itself downward. The patient died at the end of two days, and the *post mortem* examination revealed diphtheritic exudations in the trachea as far down as the division of the bronchi; at some points the exudation had been discharged.

B. INFLAMMATION OF THE SUBMUCOUS CELLULAR TISSUE.

The inflammatory affections which we have now described have been considered as confined to the mucous membrane, and not extending to the subject tissue; but inflammation does not always proceed thus; in some cases it extends deeper, and involves the layer beneath in the morbid action, constituting cellulitis, conferring additional danger and severity upon ordinary laryngitis. It sometimes happens that this extension occurs when the superficial inflammation is slight, or again is lighted up by disease of the cartilages, while the mucous membrane remains unaltered. It may eventuate in serous infiltration, or in abscess.

5.—SEROUS INFILTRATION OF THE LARYNX. (ŒDEMA OF THE GLOTTIS.)

This disease is one of great danger to the patient, and of interest to the physician for the care with which it can be diagnosed with the mirror, and the promptness of relief offered by well directed surgical aid. All the lesions of the larynx are not affected with the disease; it is confined to those into whose composition much cellular tissue enters. According to M. Sestier, in an able monograph (*Traité de l'Angine laryngée œdém.* Paris, 1852), the œdema was seen in the aryteno-epiglottic fold, 105 times in 132 cases, in which they became cylindrical, ordinarily smooth, sometimes folded, and tessellated, so that the laryngeal aperture was either reduced to a linear state or to a more or less rounded aperture. The epiglottis participates almost always in the infiltration seventy-four times in eighty-one, having the form of an almond in the extremity of the finger. Infiltration of the larynx (ventricular bands) was less frequent, fifty-two times in seventy-two; of the trachea, six times in one hundred and thirty-two cases, and of the bronchi, exceptionally only once, so that, as has already been pointed out by Cruveillier, and others, we have a supra-glottic and infra-glottic œdema. The true vocal cords are not the seat of this affection in a majority

of cases, as the name would seem to indicate, and is therefore a misnomer, and should be abandoned. In a case of convalescence for typhus-pericarditis Türk found a high degree of œdema of both vocal cords.

The disease originates in several conditions of a local laryngeal inflammation and ulceration, either of mucous membrane or cartilage in obstructive diseases of the heart and great arteries, in general purity of the blood, superinduced by severe disease of the system at large.

When œdema is observed with the laryngeal mirror, it is seen as a more or less shining, red or bluish-red swelling, usually of the aryteno-epiglottic folds or ventricular bands, as projecting across the glottic cells upon one side, or symmetrically, obscuring or totally cutting off inspection of the vocal cords, and diminishing the laryngeal aperture. The general symptoms are usually seen, more or less, in dyspnoea, cough, impairment of the voice or aphonia and dysphagia.

In illustration of this disease, and the mode of treatment, we may cite a case reported by Mackenzie, of a person 22 years of age, who applied for medical treatment, complaining of great difficulty of breathing, hoarseness and pain in the throat. He applied May the 4th, 1863, and had suffered since March, 1861, and for more than a year he had never been able to lie down at night. When he did get to sleep (in an arm-chair) he often woke with the most distressing dyspnoea, and said he felt as if he should be strangled. On making a laryngoscopic examination, the right ventricular band and aryteno-epiglottic fold formed together a large tumor, which projected across the glottis, and concealed from view the anterior two-thirds of the left vocal cord. The swelling was of a deep purple-red color. The mucous membrane over the arytenoid cartilage was also inflamed and swollen. The case was diagnosed to be one of chronic œdema of the larynx, and was freely treated with a strong solution of nitrate of silver. This treatment was continued every other day for a month, with little benefit to the patient; indeed, though the œdema did not increase, the patient became weaker, and the voice was completely extinguished. June 8th the œdematous swelling was scarified, the patient expectorating a considerable quantity of blood and frothy fluid. Two days later an examination showed the swelling but little diminished,

and the part was again lanced with great relief to the patient's suffering next day, when the laryngoscope showed the swelling much diminished, but the right vocal end rather congested. Scarification again adopted. On June 15th the patient felt quite well, scarcely a trace of the œdema remaining; but there was still a slight abnormal projection situated posteriorly over the right arytenoid cartilage, and the mucous membrane of the larynx generally was also redder than in the normal condition. The man subsequently became perfectly well.

We sometimes see more acute cases than we see above described, after exposure to cold, as described by Semeleder of two school boys who, after taking cold, were both sickened, having a slight cough; no expectoration; a rough, non-resonant voice; slight sensitiveness of the larynx to the touch, and disagreeable sensations in speaking and swallowing; when breathing quietly there was no annoyance felt. The examination with the mirror showed in both cases that the ventricular cords on both sides were œdematous; tissue of a bluish pale red color, shining slightly transparent, and protruding as swellings of the thickness of one's little finger, so far into the cavity of the larynx that the edges of the vocal cords were barely visible in uttering sounds. There were no further manifest alterations in the larynx. The stiffness and brilliancy of these swellings caused the appearance of great tension. In one of these cases it was possible to reach these swellings with the point of the finger, and feel them; they were thus found to be quite tense; after the introduction of the finger the patient felt more comfortable, perhaps because the swelling was partially reduced by the pressure. In both cases a cure followed very slowly from simple treatment.

Mackenzie also gives the testing of a case of a man, aged 30, who suffered from difficulty of swallowing and pain in the throat, which gradually came on in a fortnight. For a week he had not been able to swallow solids, and for the last thirty-six hours liquids could not be taken; attempted deglutition now invariably resulted either in a violent paroxysm of coughing, or in forced ejection of the liquids through the nares. A laryngoscopic examination showed the epiglottis to be of a bright red color and enormously swollen. The normal contour of the epiglottis was completely lost, and the valve presented the appearance

of three red, slightly projecting, semi-transparent tumors, the largest one being on the right side. The œdematous epiglottis covered the right half and the greater part of the left side of the larynx. The parts which could be observed were seen to be much congested. This man recovered after scarification of the epiglottis.

(To be continued.)

HOSPITAL GLEANINGS.

By JAMES B. BURNET, M. D.,

Of Newark, N. J.

(Continued from page 261.)

Case of Ascites.

Anna M. French; æt. 52, Irish domestic; married; admitted Oct. 28th. Patient states that she has enjoyed good health until five years ago last September, when she first noticed dropsy of the lower extremities, which increased until the following March. She took to the bed, and says that she had a great deal of pain at this time, but does not locate it other than as a general distress. She was told it was rheumatic fever. At the end of two years she was able to go about with crutches. She was in this condition for about two years, but for the greater part of last year, until her present illness began, she was able to go about and exercise as usual before her sickness. The œdema mentioned went off in the first two years, and has not returned in any marked degree since. The limbs were painful from the great swelling of the parts. She has had no cough, or shortness of breath on exercise. The menses have not occurred for the past two years.

During the past two years she has had constant pain in the back of a dull character, on standing up, and during walking. She admits habits of spirit drinking, and of taking her liquor undiluted. Bowels habitually regular; urine has been high colored; her present ascites began during the past summer; her appetite has been poor; she has noticed that since the swelling came on her perspiration, which before had been free, is now less; she now keeps the bed, but has kept up until the present time. The abdomen is very much enlarged, and presents fluctuation. The surface is œdematous, and there is erythema over the lower portion. The extremities are not œdematous, or but very slightly so. Respiration,

30; pulse, 108; sleeps poorly and appetite is deficient. She admits having been drinking freely of late. The urine is high colored, and small in quantity. It abounds in urates, but is not albuminous. It is extremely difficult for her to turn in bed. The umbilicus is depressed at least an inch. There is some tympanitic resonance, but the distension is mostly from fluid. Tongue not much coated, but rather swollen. She has been under treatment, but without any good result, the ascites constantly increasing. There is a murmur at the base of the heart.

Nov. 3d.—The enlargement of the abdomen has become very great. The abdominal walls are œdematous. Fluctuation not very distinct. Paracentesis abdominis was decided upon. The trocar was plunged into the abdomen three or four inches below and to the right of the umbilicus, but no liquid followed. Considerable liquid afterwards drained away from the œdematous abdominal walls. The patient has suffered greatly from dyspnoea, but to-day is more comfortable. The face, especially about the eyes, is considerably œdematous. The right eye is closed, and the eyelids are erythematous. The surface of the body presents a faint yellowish tint.

Nov. 7th.—Patient died on the morning of the 5th inst., at 2 A. M. She became drowsy in the afternoon of the 4th. During the night she became comatose—no convulsions. An autopsy was obtained with great difficulty, and, necessarily, limited to the abdomen. On opening the abdominal cavity, the walls were found to be 3 inches in thickness from fat. A large quantity of yellowish serum escaped when the cavity was opened, estimated at 3 or 4 gallons. There was no abdominal tumor. The liver was removed; its surface was studded with hob-nail projections of a deep yellow color. Its volume was considerably greater than in health. The weight was 6 pounds 6 ounces. Microscopical examinations of scrapings from a cut surface revealed a few liver cells filled with oil drops, and the field was crowded with oil drops of various sizes. The kidneys weighed 6 ounces and 7½ ounces. On microscopic examination, the convoluted tubes were found filled with fatty granules. The renal epithelium cells within the tubes contained fatty granules. The spleen was not much enlarged, and weighed 18 ounces. The cadaver presented a deep green color.

THE PULSE IN HEALTH AND DISEASE.

By FRED. HORNER, JR., M. D.

The distension of the arteries and the subsequent elasticity of their wall give rise to pulsation, which is perceptible to the touch and visible to the eye. This corresponds with the systole of the heart depending also upon the vital contractibility of the arterial coats. The observer should be provided with a watch with a second hand. The Chinese feel the pulse of both wrists, request silence and shut both eyes, thus concentrating the sensorial powers, as they say, in the end of the fingers. The temporal artery is convenient for examination. Hippocrates and Celsus took no notice of the pulse. Galen was the first who attended to it. Soon after birth it is 130 in a minute, 80 at puberty, 75 in middle age, and 65 in the old. In the latter the pulse is always slow and intermitting; and, according to Dr. Benj. Rush, if regular, is a sign of disease. The slowness is due to an abstraction of excitement from the muscles to the arteries, which excitement is never lost. Sex influences the frequency of the pulse; it is quicker in women. Difference of civilization modifies it. In the savage the pulse is slowest from 40 to 60, and is due to the want of stimulus of thought and labor in them. It is slower in the inhabitant of the country than in one of the city. People of different nationalities, employments and occupations present peculiar modifications of the pulse.

In the West Indies it is 100; in Greenland as slow as 40, and is slowest in the cold climates. It is slower in the winter than in summer. Is slow in the morning, quick at noon, and more frequent at night. It is slower in the sleeping than in the waking state. It is quicker on our sides when we sit up in bed or stand up, or when the arm is extended. It is accelerated by a full meal or by the use of the malt liquors, and after a hearty meal, termed by some the fever of digestion, is full and bounding. The gaseous, thread-like and soft pulse marks the existence of debility. All the passions of the mind affect the pulse. Hope and joy increase its frequency. Fear, terror, grief and anger reduce its force and frequency. Conversation quickens it. In some persons in good health the pulse is preternaturally slow or quick. In a lady, who was my patient, when in health it was not above 40, and in another the average was 100, both due, perhaps, to the abnormal position of the artery.

In disease, as we might expect, the pulse departs from regularity—in frequency or the number of pulsations in a given time, and in quickness, the greater or less time in which a pulsation is performed. It may be quick without frequency, which occurs in yellow-fever. Its frequency is caused by morbid irritability in the blood-vessels. The full, frequent, and quick pulse occurs in the beginning of pleurisy, in bilious, congestive, and yellow fevers; the tense pulse occurs in rheumatism and pneumonia; the depressed pulse, scarcely perceptible, marks malignant fever, plague and small pox; in aneurism, and diseased heart, we have the thrilling pulse, and in hectic fever that termed corded. The source of the irregularity of the pulse is almost invariably in the heart. The various anæsthetics, the virus of rabid animals, and prussic acid, often render the pulse imperceptible at the wrist. In concussion of the brain it is weak, tremulous and intermittent; in compression, irregular and unnaturally slow, and in syncope ceases altogether. Few patients recover from an acute disorder after the pulse and temperature reach a certain maximum. The pulse becomes languid just before death. From the intimate connection of the blood-vessels with every part of the body, they are to it what the dial-plate and hands are to a watch. The physician may distinguish disease by other signs; for example, the state of the tongue, respiration and countenance, the character of the excretions, the urine, sweat, and feces; yet the pulse will always furnish a valuable aid to insure correct diagnosis, and should be felt previous to venesection and to prescribing opium, emetics, purgatives, the hot and cold bath, steel, bark, and stimulating drinks or diet.

HOSPITAL REPORTS.

UNIVERSITY OF PENNSYLVANIA.

September 10, 1870.

Clinic of D. HAYES AGNEW, M. D., Professor of Clinical and Operative Surgery.

(REPORTED BY DE FOREST WILLARD, M. D.)

Ununited Fracture of the Olecranon.

GENTLEMEN: The patient now before you, John McK., at 28, comes to us with the statement that some four months since, while engaged in his occupation as a painter, he fell from a third-story window upon the pavement, receiving thereby severe internal injuries and bruises, which confined him to

his bed for some weeks, during a portion of which time he was delirious, and life was at one time despaired of; but that he finally recovered, and with returning strength and more careful examination a fracture of the olecranon process of the ulna was discovered, and the arm immediately placed upon a straight splint. Union, however, did not take place, although this treatment was persevered in for several weeks, and various expedients were then resorted to, in order to secure this desirable result, but all proved unavailing, and he now comes to us for information as to the advisability of operative interference. You will see that he can flex the forearm at will, but is almost totally unable to extend it, which fact is easily accounted for by the fact that the triceps muscle has now no firm point of attachment, and can not operate upon the fore-arm as in the normal condition.

I fix the ulna, and find that the olecranon is freely movable in every direction, and that there has not the slightest union taken place. I examine the condyles of the humerus,—they are perfectly intact, as is also the head of the radius.

Our diagnosis then plainly is, that we have to deal with a case of ununited fracture of the olecranon,—not a case of tardy union, for the time has been too long,—neither is it fibrous, or ligamentous, or fibro-cartilaginous union; but one which absolutely refuses to knit, the cause for which we are unable to assert, yet it was probably due to the presence of synovial liquid between the ends of the bones, owing to a laceration of the lining membrane of the articulation.

Union may often, also, be interfered with by excessive hemorrhage at the time of the reception of the injury, the clot sometimes entirely separating the ends of the bones; or the difficulty may be due to the presence of a fragment of bone or muscle or tendon; or to meddlesome surgery—the too often removal of dressings; or to laceration of the nutrient artery; or to constitutional taint, either of long standing or from recent debility and exhaustion; or finally, to the want of proper apposition and the consequent mobility of the fragments.

In the present case it may also have been partially attributable to the fact that the olecranon is but poorly supplied with blood, it being but a long process of the ulna, and is thus placed at a distance from its “base of supply.” This olecranon is to the upper extremity what the patella is to the lower, though Professor Owens regards it not as homologous with this bone, but with an extension of the upper extremity of the fibula above the knee-joint, which is met with in the ornithorynchus, echidna and some other animals.

In the case before us we find that all the ordinary means have failed to produce the desired result, and an operation is now certainly justifiable. Our

efforts in cases of non-union should always be to first secure immobility by appropriate splints, and then endeavor to promote activity by the use of blisters, iodine—friction of the ends of the fragments about once a week—hot and cold applications, compression, etc.; at the same time searching for and removing, if possible, all causes of delay, especially constitutional difficulties, as debility, syphilis, etc., by good food, tonics, and appropriate alteratives. Failing in all these measures, we are then driven to the severer forms of treatment, and of these we must select the one best suited to the particular case under notice. These operations are various. Acupuncture has been tried, and sometimes with good success, as has also cauterization of the ends of the bones. Dieffenbach's method is to make small holes in the fragments with a drill, and firmly drive into them a number of ivory pegs, which are allowed to remain until the irritation shall provoke union. This is good, but not applicable to the present case, by reason of its nearness to the articulation of the elbow joint, since the inflammation might be so severe as to cause extensive destruction of the synovial membrane, or of the ligaments.

The seton, first introduced by Physick, and composed of several strands of silk or wire passed between the ends of the bones, is a favorite method. The strands should be withdrawn one by one as the requisite amount of inflammation is set up.

Another method, which, however, is attended with so much risk that it should be but seldom employed, is to cut down upon the ends of the bones—saw them off, and then drilling holes in either fragment, wire them closely together, which certainly must retain them in accurate apposition and secure perfect immobility.

Still another plan is to bore through one fragment with a long gimlet, and carrying it on through the chasm, imbed it firmly in the other, thereby riveting the portions firmly together. The instrument should be allowed to remain until union has begun to take place. In the present instance, however, since the fracture is situated so near an important articulation, I shall endeavor to provoke sufficient irritation by simply perforating the ends of the bones in a number of places with a fine drill, but shall not allow it to remain, neither shall I pass it through from one bone to the other.

Much depends upon the subsequent dressing, which should be of such a character as to secure perfect rest and accurate apposition. Splints should be immediately applied, and the case treated exactly like a recent fracture. When union cannot be secured by any of these means, much relief may be afforded by appropriate mechanical apparatus.

[The patient being etherized, the drilling was then performed subcutaneously; the instrument not being withdrawn during the operation, save once to

reach the other fragment. Adhesive strips were applied over the punctures, a roller including the entire arm, with figure of eight turns at the seat of fracture, and an anterior splint, almost straight, secured to the arm.—DE F. W.]

Hydrocele.

This old man, J. A., æt. 71, presents himself with a large tumor of the scrotum, which he says has existed for 12 years, and gives no pain, but is increasing in size, and has begun to be the cause of considerable annoyance by its weight and bulk.

I discover by my questions that this tumor has been slow in its growth; that it commenced below and extended upward; that it does not decrease when he assumes the recumbent position, and that it has never been the seat of inflammation.

Upon examination, I find that it extends to the external abdominal ring; that it is smooth and elastic; that it fluctuates, and if the scrotum be pressed back between the thighs and then released, it rebounds as if attached by an elastic spring, which I regard as a very reliable diagnostic sign of this affection.

The external ring is not patulous, and coughing makes no impression on the mass, therefore it is not a hernia. It is a hydrocele, which, as you know, is an accumulation of serous fluid in the cavity of the tunica vaginalis testis, the enclosing membrane of the testicle. The normal color of this liquid is of a pale straw hue, but it may be yellowish or reddish, from the admixture of blood or pus, under which circumstances the test of translucency will be of no service, since the liquid will be opaque. The contents of a hydrocele may vary in amount from a few drachms to many ounces, and the liquid is largely coagulable by heat, showing its derivation from the serum of the blood. The tunica vaginalis is seldom altered greatly in appearance, but may at times be found thickened, and occasionally secreting pus. The tunica albuginea is rarely affected unless the fluid is long retained, in which case the testicle itself may atrophy or even degenerate.

A diagnosis can easily be arrived at by an observance of the above appearances, but in all cases a decisive result is quickly attained by the use of an exploring needle, and by its use we may always avoid the unpleasant procedure of thrusting our trocar into a sarcocele or other affection of the testicle. There is a form of this disease called congenital hydrocele, in which the vaginal tunic has never become separated from the peritoneum, the intervening canal being sometimes as large as a goose quill. In these cases care should be taken in the treatment, lest inflammation be also excited in the peritoneum, and dangerous symptoms follow. A well-fitting truss will sometimes secure separation of the cavities.

The radical cure by hydrocele is accomplished best by one of the following operations, my prefer-

ence being decidedly for the latter: The *seton* has long been used, and consists of a number of strands of silk or wire, or a strip of braid or muslin, which are carried through the tumor by means of a trocar and canula, they being pushed on after the evacuation of the contents of the sac. This seton is allowed to remain in position from 24 to 48 hours, or until sufficient inflammation has been excited to compel the obliteration of the serous cavity.

The treatment of *injections* has also been practiced for a long time, and when rightly performed is almost always successful. In performing this operation, the liquid should first be thoroughly drawn off by a trocar and canula, in order that the injected material be not diluted by the contents of the sac, and then $\mathfrak{z}\text{ij}$. to $\mathfrak{z}\text{ij}$. of undiluted tincture of iodine thrown in by means of a syringe fitted to the canula, which iodine is allowed to remain until taken up by the absorbents. The resulting inflammation is usually just sufficient to modify the sides of the cavity, and a permanent cure is effected. The presence of this iodine occasions considerable suffering for a few moments, and the patient will complain of pain along the course of the genito-crural nerve, as far back as the spinal cord; but this gradually passes away, and the trouble is inconsiderable after a few hours. The patient should be kept in bed for several days, lest the inflammation be too severe.

It was formerly customary to inject several ounces of some stimulating material, and, after allowing it to remain for several minutes, to withdraw it through the canula; but I consider the strong iodine treatment far preferable to any other. These substances used were wine, alcohol, alum, tannin, nitrate of silver, camphor, all appropriately diluted with water.

[Several ounces of straw-colored liquid were then drawn off, and $\mathfrak{z}\text{ij}$ tincture iodine thrown into the cavity, and allowed to remain. The scrotum was then suspended and the patient sent to bed for several days. DE. F. W.]

I have next to show you the patient upon whom we operated last May for

Epithelial Cancer of the Penis.

a portion of the organ being amputated at that time (Vid. REPORTER, Vol. xxiii, No. 2). He now comes to us complaining of difficulty in passing his water, saying that it will only appear in a very small stream. Upon examination I find that the cicatrix has so contracted the orifice of the urethra as to almost occlude it, and here is evidently the seat of the trouble. I shall, therefore, simply incise it and direct the man to use a steel bougie each day until all contraction has ceased. Upon examination of the inguinal glands I find on one side that they are considerably enlarged and are quite hard, showing that there is a tendency to a return of the disease, which event will ultimately undoubtedly occur; still, our operation has rendered

him comfortable for a number of months, and has added to his term of life.

My hour having nearly expired, I will simply, in conclusion, show you a case (a private patient of Dr. Garretson's) which is of interest from the fact that such slight consequences followed the reception of a severe injury to a membrane which was formerly considered so prone to take an inflammatory action. The man received a

Stab in the Abdomen

some few weeks since, the wound being several inches in length, and from this wound a considerable portion of the omentum protruded; and not only did it protrude, but it was afterward torn and bruised in a shocking manner. It was cut off and allowed to remain in the wound. The case progressed favorably in every respect, and now, although so short a time has elapsed since the reception of the injury, yet the man is in apparently good health, and says he suffers no inconvenience whatever. It is but seldom that the peritoneum will bear such rough treatment without resentment, but this and other reported cases give us better hopes of recovery from these wounds than was formerly entertained.

MEDICAL SOCIETIES.

CINCINNATI ACADEMY OF MEDICINE.

June, 1870.

Case of Encephaloid Disease.

By C. S. MUSCROFT, M. D.

Surgeon to St. Mary's Hospital.

(REPORTED BY J. W. HADLOCK, M. D.)

The patient, in this case, was a German, and by trade a tailor. He came under my care on the 31st day of last March, and presented the appearance of one who had emaciated rapidly and suffered much from the effects of disease and pain. The disease commenced in the left hip joint, and by rapid growth filled the cavity of the pelvis and part of the abdominal cavity. He suffered very much from pain in the left hip joint, which swelled somewhat, and a small tumor made its appearance over the lower part of Poupart's ligament of the same side. It was of a pale blue color, firm to the touch, and seemed to dip down into the pelvic cavity. Pulsation of the femoral artery could be traced over the tumor until it became the external iliac. Pain was not much increased by gentle restricted motion or percussion over the great trochanter or at the knee. He could lay more comfortably on the right side with his knees drawn up, but could change his position to the left side, or lay upon his back for a short time with comfort. He said his last medical attendant called his case one of hip-joint disease.

His first indisposition came on on the 26th day of last December (previous to which he had enjoyed

good health), commencing with pain in the ankle and knee joints, and in a short time extended to the hip. He was then treated for inflammatory rheumatism.

After he had been in the hospital a few days he had retention of urine, which could not be relieved without circumcision first being performed; the orifice of the prepuce being so small from congenital phymosis that a small probe could not be passed through it. After introducing the catheter into the urethra, great obstruction was found at the neck of the bladder, and in order to pass this obstruction it became necessary to introduce the index finger into the rectum. The finger at once came in contact with a tumor coming from the left side of the pelvic cavity and pressing firmly upon the rectum and neck of the bladder.

After the catheter was introduced into the bladder its orifice was directed over the left thigh, whilst the point of the instrument in the bladder was pushed over to the right iliac fossa. This examination revealed the true nature of the disease—encephaloid (cancer), and it was evident the tumor felt through the rectum was only a continuation of the one presenting in the groin, and having its commencement in or about the hip joint. The case was watched with great interest, the growth of the tumor being very rapid.

As that portion of the tumor above Poupart's ligament increased, the external iliac artery could be felt to pulsate three or four inches above the groin.

Drs. Wood, Blackman, and other medical gentlemen of the city, saw this case with me, and all agreed in the diagnosis I had made.

For several weeks previous to his death he had involuntary discharges both from the bladder and bowels. Before death occurred the tumor had extended from the left to the right iliac fossa, completely filling the true and false pelvic cavity, and encroaching into the abdomen. For several weeks prior to death the left thigh and leg was cedematous until the last week, when the cedema had nearly subsided, leaving the great trochanter and the upper end of the femur covered only by the skin and external fascia for the distance of three inches. His death occurred on the 3d of June. The last three weeks of his life he laid constantly on the right side, with the legs flexed upon the thighs, and thighs upon the pelvis. The duration of the disease from the first symptoms recognized was five months and nine days. I should add here that Dr. W. Carson, of Good Samaritan Hospital, made the autopsy of the case.

Dr. M. also reported the following case of

Ovariectomy.

Mrs. H., *et.* 36 years, a German, thought she had an abortion four years ago, at about the first month

of pregnancy. Soon after she observed a small tumor in the right iliac fossa, which gave her some uneasiness, for which she consulted the late Dr. Geo. Fries. The tumor remained small for about three years, when it commenced growing and producing more discomfort, but not at any time severe pain. By this time (April, 1869,) the swelling had extended to the right hypochondriac region, where she felt a sensation at different times as though something moved within her like a living body, and thinking herself the subject of tape-worm was treated for its expulsion.

When I first saw the case (last August), the abdomen was much enlarged, with a tumor occupying the middle and right side; extending from the pelvis to the right hypochondrium. A division of the tumor about its middle, between its upper and lower extremity, could be readily noticed.

The enlargement of the abdomen presented the appearance of pregnancy at about the sixth month. Physical examination of the neck of the uterus revealed it to be elongated and narrowed, the anterior lip being much the longest. The uterine sound passed to about the distance of two inches. Tumor could be easily felt through both anterior and posterior vaginal walls and through the anterior wall of the rectum, and also by the catheter in the bladder.

The general health was sought to be improved by appropriate treatment, and to keep the tumor (which was supposed to be a multilocular ovarian cyst of the right ovary), in check. I saw the patient regularly for five months, during which time there was no perceptible enlargement of the tumor.

The patient did not present herself to me again for some months, when, upon an examination, the abdomen was found to be much increased in size, with a more regular outline, and having the appearance of great ascites collection.

Careful examination revealed two tumors within the fluid, one occupying the lower and the other the upper half of the abdomen, both being situated more to the right than to the left side. Either tumor could be readily moved from side to side, past the other, yet it is quite likely they were connected. With the finger introduced into the vagina or rectum, the movements of the lower tumor could be distinctly felt, by making pressure upon the abdomen, and moving the tumor from side to side; but when pressure was made upon the upper tumor, no such movement could be felt. There was no cedema of the extremities. She was now frequently distressed from difficulty of breathing, and came to the conclusion that unless she could have relief from surgical aid that life would be such a burden she would rather die from the effects of an operation, which gave some hope of relief, than live to be a source of trouble to others and a misery to herself. After making herself and her husband *fully*

aware of the fatal consequences which might follow, I decided upon making, at least, an exploring operation, and carrying it as far as the circumstances would justify.

By invitation, Profs. Blackman, Wood, Dawson and several other medical gentlemen were present, all of whom agreed that an operation was justifiable.

On opening the abdomen, three large cysts were found containing between two and three gallons of fluid, which was drawn off, when two solid tumors were found attached to the left ovary. They had numerous attachments. The largest tumor had a

pedical about two and a half inches in diameter, which was firmly ligated; the pedical of the small tumor was small and not difficult to ligate. The patient bore the operation well, but died about 54 hours after the operation, I believe, from hemorrhage from adjacent parts which were wounded by breaking the tumors loose from their surrounding attachments.

[In commenting on this case in the Academy, Dr. W. W. Dawson expressed the opinion, that if the pedical in these cases was severed slowly and by degrees, with the *ecraseur*, that the tendency to hemorrhage and death therefrom, would be greatly lessened.
J. W. H.]

EDITORIAL DEPARTMENT.

PERISCOPE.

Cancer of the Larynx.

Mons. DESORMEAUX, in an essay on cancer of the larynx, quoted in the *Boston Med. and Surg. Journal*, arrives at the following conclusions:

"1st. Cancerous tissue of the larynx, being generally, if not always, composed of epithelial tissue, which offers greater chances of cure than true cancerous growth, one should never hesitate to operate for their removal when entire extirpation appears possible.

"2d. The symptoms manifested, the progress of the disease, and especially examination by means of the laryngoscope, will enable us to reach an almost positive diagnosis; and supposing even that there be an error in determining the nature of the morbid growth, the moment the tumor threatens suffocation to the patient there is an indication to resort to an operation, provided it be impossible to destroy the growth from above.

"3d. This operation is laryngotomy. We should not hesitate to freely open the parts, in order to attack the tumor with advantage and to effectually destroy it.

"4th. The danger in laryngotomy is slight. The fear of changing the voice, even of inducing complete aphonia, should not deter when the disease in question necessarily terminates fatally.

"5. When the affection originates in the larynx, removal may be attempted whenever it has not extruded above the upper orifice, a point to be determined by the laryngoscope, and so long as it has not broken through the cartilaginous case which for a long time resists its inroads. This last stage of the disease is recognized by the increased size of the

larynx, and by an irregularity of form and an abnormal firmness.

"6th. When these symptoms make it clear that complete extirpation is out of the question, or when the adjacent glands are enlarged, tracheotomy is the only resort, in order to avoid suffocation and to prolong the life of the patient.

"7th. After laryngotomy, and the destruction of the tumor, a tube should be kept in the trachea long enough to make sure that there is no recurrence. The opening thus maintained allows free exploration of the larynx from below upward, and the cauterization of doubtful points; and moreover, if the necessity for laryngotomy recurs, it simplifies the operation."

Caution in Prescribing Strychnia.

A recent number of the *American Journal of Pharmacy* has an article by Mr. CHARLES BULLOCK deserving of careful reading. A physician, in a case of paralysis, gave the following prescription:

R. Strychniæ muriat., gr. iss.
Liq. ferri iodid., ʒvi.
Syr. zingiberis, q. s. ut ft., ʒiij. M.
Sig.—Dose a teaspoonful.

The whole of this prescription was used as directed, and the bottle returned to the druggist, by order of the physician, for renewal of the medicine, the dose on renewal being increased to one and one-half teaspoonful. This was taken with apparent benefit to the patient, until the last dose, exhausting the contents of the bottle, was given. About an hour after, while at a meal, the patient complained of strange sensations, and was soon affected with tonic spasms, which are described by two medical gentlemen, who were called in, as well-marked results of an overdose of strychnia. Proper

remedies were promptly used, and the spasmodic action passed away, leaving the patient able to speak, but greatly prostrated, and, failing to respond to stimulants, death ensued in a few hours.

The bottle appeared to have been drained of its contents to make up the last dose; adhering to the bottle were well-formed crystals, some of them about a line in length and one-fourth line in thickness. Unfortunately, no chemical analysis was made to determine whether the crystals were *undissolved* muriate of strychnia or iodide of strychnia. A microscopical examination failed to carry much weight, on account of the destruction of the form of the crystal by washing previous to mounting, the size of the crystal not being accepted in evidence, as crystals of iodide of strychnia were shown nearly as large, made by simple deposition from a warm saturated solution.

The pharmacist by whom the prescription was compounded testified "that he weighed out the muriate of strychnia, threw it into a graduated measure, added the two other ingredients, and stirred them up with a bone spatula until he thought the strychnia had all dissolved, as he could see no undissolved crystals or solid matter." To a question, he replied that he noticed an opalescent appearance, resembling a quinine mixture.

So much for the history of the case. We now wish to make some remarks on the chemical and pharmaceutical character of the prescription, and throw out some thoughts on prescribing and compounding, as suggested by this case.

Muriate of strychnia is not official in the U. S. nor British Pharmacopœias, and is rarely prescribed. It is much less soluble than the sulphate, requiring 50 parts of water, at 71° F., for solution (Gmelin's Handbook).

When a drop of syrup of iodide of iron is added to a cold saturated solution of muriate of strychnia, the insoluble iodide of the alkaloid is immediately formed.

On page 1418 of the U. Dispensatory, 13th edition (1870), after quoting from this journal the experiments of BOUCHARDAT and GOBLEY on the insolubility of iodine combinations with strychnia, the authors add: "But though this fact *establishes the impropriety of combining solutions of iodine and strychnia in prescriptions*, yet it by no means justifies the inference drawn from it, that iodine might serve as an antidote to strychnia. Indeed, the contrary has been proved by the experiments of Mr. S. DARBY, who found the precipitated iodide of strychnia was highly poisonous to the lower animals, &c."

We have, in the above quotation, information given regarding the insolubility of iodide of strychnia and the impropriety of prescribing iodine and strychnia solutions in combination.

It is clearly the duty of the pharmacist to see,

when potent remedies are prescribed in solution, that the *solution is complete*. He ought, also, if allowed to dispense such articles, to be informed regarding the decompositions liable to occur, and if possible guard against mischief likely to result therefrom, or else return the prescription to the writer, with his objections clearly stated. He should also notice, when such a prescription is returned for renewal, whether any deposit has taken place in the bottle, and remove it by washing should such be the case. The question whether it is his duty to mark the bottle "shake well," when the recipe gives no such direction, is one admitting of different opinions; but we think, when so marked, the error, if any, is on the side of prudence.

We would suggest to physicians, when prescribing a remedy like strychnia in solution to its usual *full dose*, to prescribe it alone, and to give *separately* whatever else may be deemed advisable. We have in our experience been made aware of changes unforeseen and unknown to us until the event developed the facts.

Injections of Warm Water into the Tunica Vaginalis in Hydrocele.

The Boston Medical and Surgical Journal translates the following from the *Gazetta Clinica di Palermo*, No. 1, 1870: By Prof. ALBANSEE.

In the cure of hydrocele surgeons have, after the evacuation of the fluid, employed various means for the production of adhesive inflammation. The injection of iodine has long been used with good effect; but while some have sought for means of more active irritation, others, as Dr. Albansee, have employed methods more simple in their action. Prof. Albansee has studied the action of injections of air in the tunica vaginalis. Having employed them in twelve cases, he has not found any marked advantage.

In another series of experiments he has used injections of water at a temperature of 40° to 45° centigrade (107° to 113° Fahr.). The phenomena which immediately follow the operation are a trifling feeling of burning in the part, a moderate inflammation with a new effusion of fluid, and a rapid absorption. The injection of warm water has been used with success in a hydrocele which had resisted the employment of iodine. In only one patient has a suppurative inflammation occurred, and this was very probably caused by an infiltration of the water into the subcutaneous tissue of the scrotum.

CASE I.—Right hydrocele, of three years' duration, in a man 40 years of age. Puncture and injection of water at 45° cent.; retained for two minutes. There was a very limited suppuration of the subcutaneous tissue. Cured in twenty-three days.

CASE II.—Patient 23 years of age. Right hydrocele of two years' standing. There had been two-

punctures, in the first of which iodine had been used, and, in the second, insufflation of air. A puncture was made and 300 grammes of water at 42° cent. injected. The sac of the hydrocele contained 3 decilitres (10 ounces) of an albuminous fluid. Cured in eight days.

CASE III.—A man 55 years of age; left hydrocele of a year's duration. Cured in eight days.

CASE IV.—Right hydrocele and left hydro-sarcocele of syphilitic origin. Cure equally rapid.

CASE V.—Patient 56 years of age. Right hydrocele of five years, having already been treated by injection of iodine. The patient went away after the operation, and the result is unknown.

In three other cases a cure resulted without accident.

Dr. Albansee is induced by these cases to look favorably on the injections of warm water. They have certainly the merit of being more easy of application than the injections of iodine, but it may be questioned if they are, in all cases, equally reliable.

Certain Disorders of Nutrition Resulting from Lesions of the Nerves.

The Paris correspondent of the *Medical Press and Circular*, speaking of M. CHARCOT's recent lectures at the Hôpital de la Salpêtrière, says:

M. Charcot, in his second lecture, observed that the experiments of Erb, Ziemssen and Weiss have recently thrown great light on this subject by certain experiments on rabbits, whose nerves were wounded, and in which daily observations were made as to the modifications of electric contractility, which ensued in the nerves and the muscles, under the influence of continuous currents and of faradisation. If the sciatic nerve of a rabbit be wounded severely, we observe almost at once a loss of electric excitability, whether recourse is had to faradisation, or to galvanisation, and, whilst it returns slowly at the centre end, it is rapid at the peripheric end. If the lesion be slight, the electric excitability returns quickly in the central end; and never completely fails to exist at the peripheric end. With regard to the muscles, faradisation shows from the very first day a diminution, and, a few days further on, a loss of contractility. Galvanisation denotes, during the whole of the time which corresponds to the depression of faradisation, an exaltation which in its turn disappears, when faradisation becomes powerful again.

These facts are relative to conditions comparable with those which pathology presents us with. The above-mentioned observers operated as follows: Almost always they applied upon the nerve a ligature more or less tightly drawn; or, again, they produced, by means of forceps, a more or less marked crushing of the nerve. Their experiments also show that, if a nerve is cut through or excised

for a few lines, then the electric contractility diminishes in a progressive, although very slow, manner. It requires two or three months for it to disappear, and not only five to fourteen days, as when it was crushed. In this case, too, we no longer notice that opposition between faradisation and galvanisation, which was remarked when the nerve was crushed, and exists in most pathological cases. The two modes of exploration produce exactly parallel results; the faradic contractility and the galvanic contractility became weakened together, and are together reproduced in their first intensity when the nerve is restored.

With regard to the disturbances of nutrition, which ensue after lesions of the spinal cord, the skin, the joints, the bones, and the viscera themselves may, generally speaking, become the seat of derangements of nutrition, consecutive to lesions of the spinal cord and of the brain. There are some special affections which very rapidly cause all modes of muscular alteration, whether functional or organic, which lesions of the nerves have made us acquainted with. On the other hand, there are some in which electric contractility and the nutrition of the muscle preserve them in a condition of perfect integrity, during a considerable space of time, months, or even years. The muscle, in the latter case, only becomes altered after a long time, under the influence of prolonged rest. In the first class, we range the spinal diseases which do not directly modify the structure of the muscle. These are tumors, Pott's disease, partial myelitis. In these cases we have to do with very circumscribed lesions of the spinal cord, and only affecting a very limited portion of the gray substance. Next come even very extensive lesions of the white columns, provided that the gray substance be not attacked to a certain extent. I will cite, as specimens of the last class, all the ribbon-like scleroses of the posterior or lateral columns, or the sclerosis which occurs in disseminated plates, and even inflammatory softening of the cord. The second group comprehends those affections of the cord which may be followed by grave and almost immediate modification of electric contractility, and by rapid atrophy of muscles. In cases of lesions which are confined to a focus, or, being diffused, affect a great extent of the gray substance of the cord, as in spinal apoplexy, we may see very rapidly occur diminution or even loss of the electric contractility in the muscles of the paralysed limbs. This has been observed in fourteen days. As this is a disease which in general proves rapidly mortal, we have frequently occasion to remark as its consequence either atrophy or degeneration of muscles.

Central myelitis sometimes attacks both the white and the gray matter of the cord, but it always predominates in the latter. This lesion has for one

of its symptoms the diminution or prompt abolition of electric contractility. In a case of this kind an observer, Maunkopf, saw the contractility modified as soon as the seventh day. When the patients survive, it is easy to follow the progress of the other correlative phenomena; atrophy is rapid and the muscles soon are degenerated. According to Engelen and Maunkopf, the muscular lesions consist in a proliferation of the connective tissue. The nerves have always been found healthy. Fractures of the vertebral column sometimes are followed by myelitis. It is not astonishing that, in such cases, there is noticed sometimes a prompt diminution of the electric contractility.

The second category is composed of affections arising from more delicate lesions in which are exclusively affected, at least at the beginning, certain elements of the cord, e.g., some of the great nerve-cells of the anterior cornea. These are usually irritative lesions. In such cases the white matter of the cord is ordinarily intact. The type of affections of this nature is infantile spinal palsy. In this disease we may remark setting out from the fourth day, a diminution, and shortly after a complete loss, of the faradic contractility in certain muscles. Soon, also, there is observed muscular atrophy, which progresses rapidly. Some histological observations which require verification announce, in such-like cases, the simple atrophy of the primitive fasciculi with persistence of striatum. It is not known whether proliferation exists; but, at any rate, the loading with fat observed sometimes in very old cases, is probably consecutive. Around this type we may be permitted to group: 1. Spinal palsy; 2. General spinal palsy—a disease recently described by Duchesne. Its evolution is slower than that of the described diseases, but it furnishes, as far as the muscles are concerned, analogous results. Is now the law of Brown-Séquard applicable to these facts? With respect to the first group, there is no contradiction. The riband-like scleroses which do not produce rapid disturbances in nutrition, are, it is true, irritative lesions, but they affect the white columns. Now we must consider the spinal cord not as we do a great nerve; the cord, we must not forget, is also a centre. The white cords are never the direct continuation of the nerve trunks, they are commissions established between the cells. Besides, we know that the white columns are gifted with properties very different from those of the nerves which issue from them.

With regard to the diseases which compose the second group, it is indispensable to remind ourselves that the lesions attack here always principally and exclusively the gray matter. In the substance are found some elements, true organs, which appear to be in immediate communication with the nervous filaments, composing the anterior spinal

roots. I refer to the large nerve-cells of the anterior cornea. Well, the lesions of these cells, when of an irritative nature, determine—not to mention anything but the muscles—effects analogous to irritation of the nerves.

On Edible Earth.

Prof. C. W. C. Fuchs, in the *Verhandlungen des Natur-historisch Medizinischen Vereins zu Heidelberg*, Vol. 5, No. 3, says:

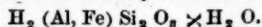
To the list of the earth-eating people the Javanese must be reckoned; a fact brought to our knowledge by ALEX. VON HUMBOLDT. From the specimens which I have had the opportunity of seeing, it is to be inferred that earths of very different external appearance and of different character are eaten. One deposit of such edible earth, possessing an intensely red color, exists in the neighborhood of Sura Baja, between strata referable to the time of the latest tertiary.

This earth is formed into thin cakes, having a diameter of from 1-1½ inches; it is then dried over an open fire, and in this condition is brought into the market. It is perfectly smooth to the touch, and is composed of materials in the finest state of subdivision. By a chemical analysis, to which I subjected it, after removing the thin stratum of soot, which settles upon it during the process of drying over the fire, I convinced myself that it does not contain the slightest trace of an organic substance. The analysis gave the following result:

SiO ₂	50.63
AlO ₃	21.32
FeO ₃	10.47
H ₂ O.....	12.97
CaO.....	2.40
MgO.....	0.33
K ₂ O.....	1.02
Na ₂ O.....	0.23

99.37

Of the water, 6.36 per cent. was driven off below red heat. The remaining 6.61 per cent. disappeared only when the test portion was heated to bright redness. From the analysis it is apparent that the earth consists of a clay rich in iron; in which is still retained small quantities, yet undecomposed, of the minerals from which it derived its origin. In this way the trifling per centage of potassa and soda may be accounted for. Taking away the accessory alkalis, and so much of the silica as they demand, there remains behind a clay of the formula:



Humboldt suggested that the probable explanation of the earth-eating habit might be found in the desire to fill the stomach, and thus, in a measure, to allay the pangs of hunger. This view of the subject may be satisfactory when applied to those rude people who devour it in great quantity; but it will

not apply to the case of the Javanese, who make use of but trifling quantities. With these it is much more probable that the physical properties of the earth alone are sufficient to furnish the cause we are seeking.

Upon rubbing it, not the slightest grittiness is perceptible, and on being moistened with water it forms a smooth and unctuous mass. The enjoyment derived from eating it seems to reside in the similarity of the sensations it produces, with those derived from the eating of fatty substances. In many parts of Württemberg the quarrymen have the habit of eating the smooth, unctuous clay which collects in the fissures of the rocks. The term "Mondschmalz," which they apply to it, would seem to refer to the enjoyment they experience in the process of eating.

Neuralgia of the Jaw-Bones.

Prof. GROSS says (*Am. Journal Med. Sciences, and American Practitioner*): "There is no form of neuralgia of the jaw-bones which, as far as my information extends, has not hitherto been described. Its seat is in the remnants of the alveolar process of edentulous persons, or in the alveolar structure, and in the overlying gum, and is met with chiefly, if not exclusively, in elderly subjects. It is more common in the upper than in the lower jaw. The part affected is usually very small, often not exceeding a few lines in extent. The soft tissues around do not seem to suffer, at least not in the same degree; on the contrary, the morbid action is generally limited to the osseous structure. In rare instances there may possibly be some involvement of the gum, which is nearly always exceedingly hard and dense, grating more or less under the knife, and adhering with extraordinary firmness to the atrophied alveolar process beneath. The pain is generally paroxysmal, coming on in fits and starts, very much as in ordinary neuralgia, the slightest causes being sufficient to provoke it, as talking, mastication, the contact of hot or cold fluids, deglutition, or mental excitement. Sometimes it is momentary, coming and going with the rapidity of lightning; occasionally it lasts for hours together, and cases occur, although they are rare, in which it continues, with but little mitigation, for an indefinite period. The pain varies in character; thus it may be sharp and darting, dull, heavy, aching, boring, or gnawing. Pressure generally relieves rather than aggravates it. Now and then, when it is uncommonly severe, there may be more or less spasm of the muscles of the face, but this is rare. The pathology of the affection seems to be compression of the minute nerves distributed through the wasted alveolar process, dependent upon the encroachment of the osseous matter upon the walls of the canals in which

they are naturally inclosed. The disease usually comes on gradually, and proceeds from bad to worse until, in many cases, the suffering is rendered nearly intolerable. The only effectual remedy is excision of the affected alveolar process. No particular attention need be bestowed upon the after-treatment. A mild course of chalybeate tonics may be required when the patient is anæmic, or affected with flatulence and indigestion."

Reviews and Book Notices.

NOTES ON BOOKS.

Mr. CAMPBELL, of Boston, the publisher, sends us the second volume neatly bound, January to July, 1870, of the *Journal of the Gynecological Society of Boston*. This journal, it is known to our readers, is issued monthly under the editorial supervision of Drs. WINSLOW LEWIS, H. R. STOREY, and GEO. H. BIXBY, and we may say here *sotto voce*, that it is about the *spiciest* journal that we wot of. The bound volumes are furnished at \$2.50 each.

The second number of the *Archives of Ophthalmology and Otology* is very rich in material of special interest to those engaged in these specialties. It contains 26 articles by prominent American and German writers on these topics, many of which are beautifully illustrated with superior wood cuts and lithographs. The *Archives* is edited by Prof. H. KNAPP, M. D., of New York, and Prof. S. MOOS, M. D., of Heidelberg, and is published simultaneously in English and German, and issued in the best style. It is published in New York by Wood & Co.

An interesting pamphlet on the "Physiological Action of the Nitrous Oxide, as shown by experiments on man and the lower animals," by Dr. R. AMORY, of Brookline, Mass., has been republished by the *New York Medical Journal*. It is enriched by a number of sphygmographic drawings. Price 50 cents. Published by James Campbell: Boston.

As an evidence of the general favor with which Dr. FORWOOD's valuable work on the MAMMOTH CAVE, of Kentucky, has been received, we need only state that the first edition was exhausted in about six weeks from the date of its issue, and that a new edition is now ready for delivery. The rapid sale of the first edition has enabled the author to reduce the price to \$2.00 per copy, post paid. All orders sent to this office will receive their attention.

Hearth and Home, one of our most valued exchanges, one of the best family papers published, has passed into the hands of Orange Judd & Co. It has been so good that we hardly know how it can be

made better—but, if any one can improve it, Orange Judd is that man. \$3.00 a year; \$2.50 with THE REPORTER.

The *Galaxy* is one of the best, most vigorous, wide awake, monthly literary magazines. The New York *Evening Mail* says of it:

"In the good sense of the word it has shown more of the spirit and enterprise of 'Young America' than any other of the monthlies. It has not refused the aid of the old and well-known writers, but it has never hesitated to give its imprint to articles of originality and merit from those who had to make their reputation through the *Galaxy*. It violated all the old magazine precedents by publishing the names of contributors, thereby offering fresh incentives to young writers and enlarging its list of 'available' articles, by absolving itself from full responsibility. The reform which it thus began its contemporaries have been forced, one by one, to adopt in one way or another.

"Its editors have also shown their enterprise in procuring articles on fresh and timely topics. The *Galaxy* has thus had something of the fresh and lively interest of the newspaper. Lately it has brought about the discussion of important historical and political questions by men of high official standing, and thus, in another way, enlarged its interest; while such articles as those of Justin McCarthy on foreign politics and notabilities have been equally interesting and instructive."

From statistics published in the *American Publisher and Bookseller*, we learn that the publication of medical books in the United States is decreasing every year. The figures representing the number of works published in 1868 and 1869 are respectively 97 and 89. While the issue of publications on art and literature have fallen off in the same period, the number of works of fiction has increased by more than one-fourth. An ominous index of the degenerating tastes of our day.

There has been somewhat of a revival of medical literature in Spain. Among recent acquaintance we may notice the *Pabellon Medico* as conducted with much spirit, and the *Gaceta Medica de Granada*. Spain has now about half a score of medical publications which follow pretty closely in the track of science. Of those of our contemporaries whose appearance we miss during the current year we may mention with regret the *Escholaste Medico*, the best known medical periodical of Portugal, which has come to an end after a career of twenty-six years' duration under the auspices and support of the government, and under very talented direction. We can say scarce less of the *Hygiene Militar* in Madrid, also in connection with the army, which, after a shorter term of existence, came to an end in Spain a year previous, though maintained through-

out with much ability. Both these governments deserve credit for advanced undertakings, in which we lament to have seen less perseverance in their original views.

The latest of all the directions of hygienic literature is certainly a French book on the "*Hygiene des animaux*" by André Sanson. The author does not occupy himself so much with the means of preserving the health of animals as with the means capable of rendering them healthy or diseased, to the extent most conducive to the profit of their proprietor. It is, therefore, a treatise on hygiene devised from the point of view of the breeder, not of the animal.

We have received from the agent "An Account of the Medicinal Properties of the Healing Springs, Bath county, Va., to which is added a few certificates of cure." There is no doubt of the high value of the mineral springs of Virginia, but we do not like the style of the pamphlet, with its certificates of cures and its exaggerations.

The *Journal of Speculative Philosophy* is now in the fourth year of its existence—an unusually long life for a periodical of that class. In the last number F. A. Henry discusses the speculative phases of "The Finite and the Infinite;" W. R. Walker continues his translation of the famous Mediations of Descartes; Mr. Harris, the editor, contributes a translation of Hegel's Exposition of the Philosophy of Plato, and commences a series of "Contributions to Philosophy" designed for new beginners; D. J. Snider translates from Rosenkranz some remarks on Goethe's Social Romances; Mr. Kroeger furnishes two translations—one a characterization of Beethoven's F Minor Sonata by Marx, and the other an Art-criticism of the Book of Job by Herder.

The work is published by Wm. T. Harris (Box 2398, St. Louis, Mo.), at \$2 per year.

We have taken much interest in the various numbers of this journal, but regret that it is not conducted more in accordance with the views of modern scientific psychology. We wish to see in it more original matter, more modern facts, and less of the *bis crambe repetita* of the German ideologues. It neglects altogether the researches of the last score of years, and is a truer representative of the metaphysics of 1840 than of 1870.

The firm of J. B. Lippincott & Co. have commenced the publication of two new medical periodicals. One is the *Photographic Review of Medicine and Surgery*. It is to be a bimonthly, each number containing four photographic plates with notes and remarks. Subscription, \$6 a year. The other is a biweekly called the *Medical Times*, intended to be especially an organ for Philadelphia and its schools. Its first number has appeared, and is creditable in appearance. Terms, \$4 a year.

MEDICAL AND SURGICAL REPORTER.

PHILADELPHIA, OCTOBER 8, 1870.

S. W. BUTLER, M. D., D. G. BRINTON, M. D., Editors.

Medical Society and Clinical Reports, Notes and Observations, Foreign and Domestic Correspondence, News, etc., etc., of general medical interest, are respectfully solicited.

Articles of special importance, such especially as require original experimental research, analysis, or observation, will be liberally paid for.

To insure publication, articles must be practical, brief as possible to do justice to the subject, and carefully prepared, so as to require little revision.

We particularly value the practical experience of country practitioners, many of whom possess a fund of information that rightfully belongs to the profession.

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AN EXTRAORDINARY GENERAL ORDER.

We were surprised, not long since, at seeing a general order from the headquarters of the army, which virtually constitutes the captain or lieutenant commanding a company its chief medical officer. The order referred to is General Order No. 75, current series, and is dated Washington, June 23, 1870, and reads as follows:

"By direction of the Secretary of War, the annexed form of company sick report is adopted for use in the army.

"Blank books, with the prescribed form will be furnished by the quartermaster's department.

"By command of General Sherman.

"E. D. TOWNSEND,
"Adjutant General."

The form referred to, after the customary headings for the entries by the first sergeant and by the surgeon, has the following printed statement, to be signed as directed by the note:

"The above cases have been examined by me before being sent to the surgeon.

"Captain (or Lieutenant) Commanding Co.

"The examination may be made and this list signed by any commissioned officer of the company."

The effect of this extraordinary order is that no enlisted man can have the privileges of medical attendance, either in quarters or in hospitals, unless the commissioned officer who has charge of the company—who has not, and don't profess to have any tincture of medicine or surgery—diagnoses his complaint to be real and of sufficiently grave character to require treatment!

We venture to say that there is no other army in the civilized world where the line officers are thus constituted *ex-officio* surgeons, and where the men are thus deprived of medical aid through the ignorance of their superiors—an ignorance not at all blameworthy.

We are very confident this order was issued without consultation with the Surgeon General, or any of the distinguished members of our army medical staff. It is altogether too conspicuous a solecism in professional science to meet with approbation from experienced surgeons.

If such an order had been in force during our civil war, the mischief it would have worked would have been great and manifest. As it is, the limited numbers in our regular army, and the intelligence of the line officers, we doubt not, will combine to conceal its bad

tendencies. But that is an unwise arrangement which would fail on a large scale and which depends on temporary conditions.

Moreover, it conveys nothing short of an avowed suspicion of the ability or honesty of the attending surgeon, and, therefore, is an insult to the medical staff at large. The result of such arrangements will be that the medical corps of the army will be deserted by its best men, and no enterprising and ambitious young surgeons will be found to accept positions which notoriously expose them to injurious and degrading suspicions.

Notes and Comments.

☞ Mr. JOSEPH H. SWAIN will call on a portion of our Philadelphia subscribers, beginning next week. This will be his *twelfth* visit to some of them, his first connection with THE REPORTER dating from October, 1858. Mr. Swain will receive also any *new* names that may be handed to him.

☞ We have effected very complete arrangements for Medical Society and Clinical Reports in this city, and items of special interest to our Philadelphia readers. In this department of work we shall have the aid of Drs. RALPH M. TOWNSEND and DE FOREST WILLARD. Very little space, however, will be occupied with anything that will not be of equal interest to *all* our readers, whether they reside in this city, Iowa, Georgia, New Mexico, Montana, Texas, or Idaho.

The Medical Institute.

Those of us who are growing into the "serè and yellow leaf," remember the old "Philadelphia Institute," founded, we believe, by Chapman, Hodge and others. We hold its diploma and are proud of it. For many years it disappeared from the list of preparatory medical schools in this city. We welcome it back, however, now under the guidance of Drs. HODGE, BOLLING and HUTCHINSON. Winter examinations and a summer course are given in connection with the course in the University of Pennsylvania. These gentlemen are all experienced teachers and lecturers.

Congenital Deformities.

We trust that our readers have not failed to read Dr. BATTSON's very interesting article on Dropsy of the Amnion, in the two preceding numbers of THE REPORTER. In connection with the theory therein advanced, Dr. Battson says, in a letter recently received: "Since I wrote the article I have attended

a very interesting case. A club-footed child had been born living, and I was sent for to deliver the placenta four hours afterward. It was adherent throughout the whole extent, firmly glued to the walls of the uterus. I introduced my hand and carefully and successfully extracted the whole of it. No hemorrhage. The old mid-wife had broken the cord short off. The previous history, pain and tenderness, pointed to placentitis."

Errata.

In Dr. BINKER's article in THE REPORTER of September 10th, the following errors occur: Page 201, first column, eighth line from bottom, read, "degree of *shock*," etc. Page 202, first column, ninth line from bottom, read, "*twenty-two* seconds of time." Page 203, tenth line from end of article, read, "*expensive*" instead of "offensive."

Quantity of Carbonic Acid Contained in the Air of School Rooms.

Dr. BREITING (*Chem. News*) made a series of fourteen experiments, beginning at 7:45 A. M., and continued to 4 P. M., in a room of 251.61 cubic metres' capacity, and containing 64 children. The quantity of carbonic acid contained in the air of that room during these experiments varied from 2.21 to 9.36 per cent., while free open air contains four ten-thousandths of that gas; and a quantity of 1 per cent. of the same gas present in air is considered injurious to health.

Purification of Chloral Hydrate.

Prof. F. A. FLUECKIGER states (*Pharm. Cent. Halle*) that much of the commercial chloral hydrate is impure, and unfit for use until purified. It is usually met with in irregular masses containing moisture, and having a sharp, pungent odor, indicating partial decomposition. The salt may be readily purified by dissolving it in *pure* bisulphide of carbon (soluble in forty-five parts of the menstruum at 18° C.) and allowing the salt to re-crystallize by the spontaneous evaporation of the solvent. The product appears in colorless prismatic crystals, not hygroscopic, and free from acid reaction.

Clearing of Muddy Water.

Dr. C. Schloesing states, in an article in the *Comptes Rendus*, that waters contaminated by floating particles of clay may be readily clarified by small quantities of salts of lime. It is well known that the waters of rivers, after a heavy fall of rain or snow, and sometimes throughout the winter, do not become quite clean by deposition, even if left undisturbed in large reservoirs for a long space of

time. The author recommends the addition of 1-1000th part of chloride of calcium for one part of water (or 70 grains to the gallon), a quantity which effects clarification in a moment. The precipitated substance can be readily separated by filtration. Other salts of lime, such as the nitrate and bicarbonate, and caustic lime, effect the same object.

Domestic Homœopathy.

A correspondent of the *Homœopathic World* has carried his faith in the principles of the system to its logical conclusions, and is quite satisfied with the result. He is evidently one of the believers in the doctrine that trituration develops power, and this gentleman has tried the experiment on tea. He finds that 60 grains triturated to a fine powder will yield a better infusion than 75 grains treated in the usual manner. As a matter of course, too, the tea is more promptly prepared by using the leaves in powder; but as the trituration would occupy the same time, we cannot see much economy in this.

The *Melbourne Argus* recently contained the following paragraph, and in transcribing it to our pages we may add, that if this should meet the eye of the consignee of these antipodean leeches, we should be glad to see a few of them on their arrival, as from personal experience of their value we have a rather special affection for leeches generally: "Few persons have any conceptions of the magnitude of the leech trade. France is said to consume annually 100,000,000 of leeches. England and Germany the same, and other countries in proportion. From official statistics of France, Germany, Russia, Italy, and Turkey, it has been gathered that the prime cost of leeches sold in Europe exceeds 2,000,000*l.* per annum. Some parts of Australia abound with leeches, those which frequent the Murray river being preferred by the medical faculty to any other known specimen. They bite freely and leave no inflammatory wound or mark behind. They thus equal, if they do not surpass, the famed freckled leeches of Northern Europe.

Correspondence.

DOMESTIC.

Mother's Marks.

EDS. MED. AND SURG. REPORTER:

Whatever size my "bump" of casualty may be, I am confident that of marvelousness is small. I have no respect for the thousands of vagaries, born of ignorance and nourished by superstition, which have

been handed down from mother to child and allowed to pass unquestioned until they are regarded as facts. In almost every grade of society we find, for example, a set of *lunatics* who can not do anything unless the moon is in the right phase. Splitting rails, sowing seed, weaning babies, and an infinite host of similar acts must not be commenced without first carefully consulting the almanac. I said I had no respect for such notions. I might say I have no patience with such nonsense. The science of medicine is far from free from these hereditary taints. One of the most popular and deeply-seated notions of this nature is the belief in the origin of mother's marks. Disappointed desires, frights, and dreams are the principal causes assigned for these imperfections.

I am not surprised that persons, who, though educated and intelligent, consult "fortune tellers," should believe in the popular cause assigned for mother's marks; but I am frequently astonished to find medical men of fair reputations, if not actually countenancing these absurdities, certainly not trying to refute and enlighten. But recently in consultation with a physician of this city, in a difficult case of obstetrics, I noticed the nurse bathing the temple of the new born child with the blood from the placenta. On inquiring for the reason, I was informed by the physician it was to *cure a mother's mark!* As for me, I have as much faith in the cure as in the cause, as generally believed.

I had occasion, last winter, to attend a clinic at the Women's College in this city, when a case of *nævus* came up for treatment. I am glad to say, the professor of surgery gave no encouragement to the absurd theories offered by most of the students, but took issue with one of the woman professors, whose age and reflection ought to have taught her better.

In number 702 of THE REPORTER, a case of *nævus* is referred to, and this singular language is used: "Early in the pregnancy of the mother, she had an intense longing for the flesh of some beavers which her husband had killed and brought home. He refused to let her eat it." Is it possible the writer would have us believe that the "longing" or the "refusal" had anything to do with the deformity? It seems to me quite as reasonable to say that club-foot, hare-lip, six fingers, spina bifida, or any other malformation is caused by ungratified longings, frights or dreams. Is it not the duty of every physician to combat, explain and, if need be, ridicule every such evidence of ignorance and superstition out of society? I am not of that class who will not believe anything unless capable of explanation. I will believe the moon is made of green cheese if a series of uniform, consistent facts are presented to support that statement; or even that a grain of burnt clamshell can be divided into as many parts

as there are grains of sand in the whole earth, allowing the globe to be *all* sand, and still exert appreciable medical effects, but I will not believe it because some Rip Van Winkle says so.

C. H. MERRICK.

Cleveland, Ohio, Sept., 1870.

[Whether or not mental emotion can affect the nourishment of the fetus and cause "marks," is still *sub judice*. Dr. Hammond, in an excellent article in the *Journal of Psychological Medicine*, says it can, and, our correspondent to the contrary notwithstanding, we agree with Dr. H. Last year, in the *American Journal of Insanity*, a writer took strong grounds against the doctrine. But it must be remembered, one positive instance outweighs a thousand negative ones. There are examples which, if they do not prove the doctrine of "mother's marks," show coincidences far more astounding than the doctrine itself. If our correspondent has not read Dr. Hammond's article, we recommend him its perusal.—EDS.]

"Those Worms" Again.

EDS. MED. AND SURG. REPORTER :

I notice in your issue of the 24th ult. a few lines of criticism from Dr. ELLIOT COUES. He says that "tape worms there are, and earth worms, and other worms; there is a worm in the bud, and a worm 'that dieth not,'" and finally becomes so condescending as to agree that there is a substance in the dog's tongue called a worm; but, continuing, he says, "the relation, if any, between this anatomical structure and hydrophobia awaits demonstration." Now I am well aware that "there is need of *more information* on the subject," and, for this reason, consider myself justified in retaining my opinion, until it has been proven by "demonstration" and "more information" to be false. When I sent that letter to be published I did not intimate that what I said should be received as a *fact* without further information on the subject; but I hoped it might lead to the discovery of a remedy which would prevent madness from occurring in dogs.

I spoke rather plainly, it is true, but my belief in the remedy was, and is still so great, that I could not speak otherwise; but, to return to my critic: "He regrets (poor fellow), that he can give no information on worms in *dogs tails*, as he has not yet investigated that kind of antero-posterior symmetry," which reminds me of the fellow who, when asked by a musician if he could play on the violin, replied that he did not know, for he never *tried*.

Perhaps my learned critic will condescend at some future time to investigate the "antero-posterior symmetry" of some canine, and thereby ascertain whether or no there is a substance resembling that found in the tongue, and which I call, for want of a name, a *worm*.

I agree with you, Messrs. Editors, that "the surgeons who would catch hold and operate upon a mad

dog are extremely scarce;" but I can not imagine how such an idea occurred to you. I did not, in my letter, so much as intimate such a proceeding, as you will ascertain by examining it closely again; but I wished it understood that the operation was to be performed when the dogs were in a perfect state of health and free from hydrophobia, in order to *prevent them from taking the disease*, as I believed the operation would remove their susceptibility to it.

E. LYNCH, M. D.

Lancaster, Ohio, Sept. 28, 1870.

NEWS AND MISCELLANY.

—We understand that Mr. FOUGERA, of New York, the well known French pharmacist, has given \$1,000 toward the fund for the relief of the wounded of the French army, and offers to be one of one hundred more to raise \$100,000 for the same purpose.

QUERIES AND REPLIES.

Dr. A. W. S., Pa.—What magnetic battery is the best for general medical and dental use, and what is the price?
Ans.—Kidder's, \$20.

Are the French microscopes advertised by instrument makers, and costing from \$5 to \$10, worth anything?

Ans.—No; except for the amusement of children.

MARRIED.

JONES—JACOBS. At the residence of the bride's brother-in-law, J. H. Parsons, Esq., Ypsilanti, Mich., Sept. 22, 1870, by Rev. M. A. Hyde, officiating at St. Luke's, Miss Emma L. Jacobs, formerly of Guilford, Vt., and Samuel L. Jones, M. D., of Deerfield, Mich.

BAILEY—STORY. In Woodstock, Vt., Sept. 1st, by Rev. C. C. Thornton, Royal L. Bailey, of Vernon, Wis., and Miss Susan Lawrence Story, daughter of the late Dyer Story, M. D., of West Windsor, Vt.

LIVERMORE—CLARKE. At Paris, France, Aug. 30th, at the United States Legation, by Rev. Mr. Marshall, Frank Livermore, M. D., formerly of Cambridge, Mass., and H. Lalla, eldest daughter of W. H. Clarke, Esq., of New York.

MUDD—MERRELL. In Cincinnati, Sept. 21st, at the residence of the bride's father, by Rev. S. L. Spalding, Dr. Wm. A. Mudd, of New Haven, Ky., and Miss Mary J. Merrell, of Louisville.

PERRINE—BROWN. In Cincinnati, Sept. 20th, by Rev. Chas. L. Thompson, Wm. K. Perrine, M. D., and Miss Emma L. Brown, all of Cincinnati.

YOUNG—LOCKWOOD.—At Riversdale, Conn., by Rev. J. S. Dodge, Dr. J. B. Young and Miss Carrie E. Lockwood.

DIED.

JONES.—At Washington, D. C., Sept. 19th, Louisa M. Jones, daughter of Dr. J. W. McMahon, of this city, and wife of J. Shipley Jones, aged 46 years.

REED.—In Barre, Vt., Sept. 16th, Mrs. Elsie M. Reed, wife of Dr. O. H. Reed, aged 37.

SARGENT.—At New Brighton, Pa., Sept. 15th, Dr. John Sargent, in the 71st year of his age.